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Therapist Feelings of Incompetence: Their relationship to the Working Alliance and Treatment Outcome.

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ABSTRACT:
This study set out to explore therapist feelings of incompetence (FOI) in the therapeutic process from both a quantitative and qualitative perspective. While previous studies have explored therapist descriptions of such feelings, this is among the first attempts to look at the role of these specific feelings in an individual therapy session using therapist and patient data. The results revealed that therapist feelings of incompetence impact the working alliance directly and outcome change indirectly, through the working alliance. Furthermore, qualitative analysis suggested that therapist feelings of incompetence might be associated with specific avoidant behaviors which may negatively impact the working alliance. Next, this study proposed possible remedies for these avoidant behaviors, from training in reflective listening to deliberate practice focused on tolerating unpleasant emotions. Future directions for research might focus on looking at FOI across whole treatments and the role of these feelings in alliance rupture and repair.

Chapter 1:

Introduction

Why are some psychotherapy treatments more effective than others? Many studies have indicated that there is something about the quality of the therapist who is administering the treatment - more so than the modality - that leads some treatments to produce better outcomes than others, with therapist personality factors contributing up to eight times more to patient outcomes than the specific modality (Lambert, 1989). This certainly comports with most therapists' experience: there are good and bad CBT therapists, good and bad psychodynamic therapists, good and bad therapists across every modality. What is it, then, that makes a good therapist "good," if it is not the

modality that they choose to employ? Since thoughts and feelings are a primary domain of the therapist, perhaps, a therapist's thoughts and feelings - and how they manage them - play a key role in producing successful treatments. This dissertation will seek to understand one particular component of therapist feelings - that of incompetency - and how it informs the therapeutic relationship and therapeutic outcomes.

There is evidence that feelings of incompetence among clinicians are widespread, even among more experienced therapists (Theriault and Gazzola, 2005**)**. Therapist feelings of competence/inadequacy merit more investigation as they relate to the therapeutic alliance because these feelings could theoretically lead therapists to withdraw emotionally from the treatment, thus harming the alliance, if the therapist's own negative feelings are overwhelming (Thériault, Gazzola and Richardson, 2009**)**. However, one could also imagine that therapists who feel inadequate are likely to invest time and resources into understanding a patient who confuses or challenges them (Thériault, Gazzola and Richardson, 2009**)**. Indeed, at least one study, focusing on CBT therapists, found that therapists who judge themselves the most harshly, are, in fact, determined to be the most competent by third party evaluators (McManus, 2012).

One way of understanding therapist feelings of competence and inadequacy is through the lens of countertransference, a concept that is less studied quantitatively, though written about extensively as a matter of theory. Countertransference is defined by different theorists in different ways but broadly describes the therapist's conscious and unconscious reactions to their patient (Kernberg, 1965) with disagreement about the extent of patient and therapist contributions to the therapist's reaction. Some theorists, originating with Sigmund Freud, have suggested that countertransference is

an affective experience to be managed and neutralized by the therapist (Freud, 1912), while others have argued that countertransference is a therapeutic tool to be utilized in helping patients and improving outcomes (Heimann, 1949). Within countertransference there are different factors that reflect the range of reactions therapists may have in response to the patients, including incompetency, making countertransference a meaningful way of trying to understand such feelings.

No matter how one understands countertransference, it is impossible to separate it fully from the therapeutic alliance, another key construct that seeks to measure and explain the therapist-patient relationship. The therapeutic alliance is often also referred to as the working alliance or therapeutic working alliance. The therapeutic alliance, which is widely accepted to permeate all modalities, can be understood as an evolving agreement between therapist and patient on the patient's goals for treatment, how to best achieve them and the nature of the bond between therapist and patient (Bordin, 1979). Indeed, numerous studies have confirmed the significant role that the therapeutic alliance plays in influencing the outcome of psychotherapy (Duncan et. al, 2010**)**.

When it comes to measuring therapeutic outcomes, they can be understood in many different ways from a change in basic functioning (Lambert and Hill, 1994) to a change in a patient's personality structure (Mayer, 2004). Still others question the possibility of measuring a psychotherapy outcome at all (Kazdin, 1991). For the purposes of this dissertation, the focus will be on the most commonly used measure, which is that of basic psychological functioning as measured by the Outcome Questionaire – 45.2.

In order to understand how feelings of incompetence in the countertransference are related to the therapeutic alliance and to therapeutic outcomes, it can be useful to focus on short term treatments. Practically speaking, this is because most psychotherapy treatments are indeed short term, with an average of less than five sessions, no matter the popular conception of psychotherapy as a long, drawn out process (Hansen, Lambert and Forman, 2002).

Given the widespread occurrence of feelings of incompetence and a relative lack of literature on this phenomenon, it is logical to study the relationship between feeling incompetent and the therapeutic process. The aims of this dissertation are multifold: First, to explore feelings of incompetence in short term dynamic therapy as expressed in the countertransference as they relate to the outcome. Second, to understand the relationship between countertransferential feelings of incompetence and the working alliance, both within each session and across each treatment. Third, to determine the association between therapist feelings of incompetence and therapeutic outcomes both within each session and across each treatment.

Therapist Feelings of Incompetence

There are many ways that psychologists have described the therapist's feelings of doubts about their own competency, several of which will be described in detail in this section. Building off the work of Canadian psychologists Theriault and Gazzola, this paper will use the term “feelings of incompetence” or FOI to describe this constellation of feelings, which include inadequacy, helplessness, ineffectiveness and other similar emotions. Additionally, the countertransference measure that will be used to measure these feelings, the Countertransference Questionnaire, groups together these feelings

in a category known as “helpless/inadequate” with questions that use inadequate and incompetent almost interchangeably, making FOI a reasonable umbrella term for this set of feelings (Betan and Westen, 2009). This section will explore existing theory and research on therapist FOI by examining the sources of FOI, the effects of FOI for therapist performance and well-being, the responses of therapists to their FOI and lastly, contradictory findings about the prevalence of FOI in therapists. Finally, this section will summarize gaps in the literature the dissertation aims to address.

Therapists writing anecdotally and in case studies about their FOI attribute these feelings to apparent patient apathy or failure to make progress. One therapist writes that “I felt very uneasy and inadequate” when a teenage patient was apathetic about working with her and told her so (Dryden,1992). In another collection of therapist essays, a counselor writes about an experience with a patient who eventually left abruptly from therapy, “..what am I really doing? She is placing so much faith in me and what I have to offer seems so shallow (Mearns, 1990).” More description is provided in an interview with a counseling psychologist about her work with a severely traumatized patient: “I remember feeling completely overwhelmed by how I was supposed to help her given the severity of her concerns and the limited number of sessions we would have together... I felt myself struggle to instill hope in a situation that just felt so unfair (Smith, 2017).”

Therapist’s feelings of incompetence have a negative impact on the therapist, often in the form of burnout, stress and fatigue (Simionato and Simpson, 2018). Deutsch found that therapist stress was related to feelings of “personal inadequacy or even incompetence,” as well as fears of ineffectiveness (Deutsch, 1984). Transcript analyses

in another study about therapist stress cited feelings of failure - which one could compare to feeling incompetent - in 74% of therapist participants (Farber and Heifetz, 1982). These studies, which were conducted during a time when workplace burnout was being examined across fields, consistently showed that therapists attributed their stress to a sense that they were not competent or effective at their work.

In addition to burnout, feelings of incompetence have been associated with a host of other negative phenomena associated with the treatment, itself. In one example, researchers surveyed 339 psychotherapists and found that a significant number of participants identified their own feelings of incompetence as a “hindrance” to successful terminations, such as in the case of premature or delayed terminations (Brady, Guy, Poelstra, & Brown, 1996). In his reflections on working as a psychoanalyst, Dr. Herbert S. Strean describes how feeling “helplessness” with multiple patients led to breakdowns in the therapeutic relationship and worse results for his patients (Strean, 1993). These clinical narratives all indicate that there are meaningfully harmful problems associated with FOI, both for the therapist and the patient.

Research has been mixed on whether these feelings of incompetence fade among therapists as they gain experience in the field. An international survey of 3900 therapists with a range of experience found that self-reported “perceived therapeutic mastery” was correlated with years of experience such that more experienced therapists considered themselves more effective (Orlinsky et. al, 1999). This finding is complicated by a later study, focused specifically on experienced therapists’ feelings of incompetence and using a qualitative approach, that reported deeper, more powerful and more complex feelings of inadequacy that persisted years later (Thériault and

Gazzola, 2005). In that study, the authors interviewed eight clinicians with 10-29 years of experience and then used a grounded theory methodology to code the interviews, concluding that there were three categories of FOI, each with increasing intensity. These ranged from moment-to-moment feelings of ineffectiveness to insecurity ("someone could be better than me") to the most extreme, feelings of self-loathing or worthlessness. These two studies expose the complexity associated with feeling incompetent, both in the effect of experience and in the varying degrees of intensity.

Thériault & Gazzola's studies on feelings of incompetence in both novice and experienced therapists shed light on the potential implications of such emotions (Thériault and Gazzola, 2005; Thériault, Gazzola and Richardson, 2009). Their first study, on FOI in experienced therapists, discussed above, laid bare the potential for incredibly intense emotional turmoil that can accompany feelings of incompetence. In a study several years later focused on novice therapists, they explored more deeply the effects of these feelings (Thériault, Gazzola and Richardson, 2009). Similar to the previous study, they conducted, recorded and coded open ended interviews, this time with ten therapists with an average of two years of experience, nine of whom were women. The prompt was, "What would you say are the most important aspects of [feeling inadequate as a therapist] for you?" and therapists were encouraged to respond at length.

Using open coding, they found two almost contradictory responses. On the one hand, several therapists expressed that their FOI led them to "proactively address areas of felt weakness: they read more, consulted, and sought feedback, supervision, and advice," as well as increasing their reflexivity and efforts to analyze their relational

dynamics with their patients. On the other hand, therapists spoke about the negative feelings and behaviors that arose in response to FOI, such as “paralysis,” a diminished sense of self and a “distraction-disengagement-detachment continuum.” Among these therapists, one therapist reported favoring short term work to mask a sense that their patients dropped out early. These results suggest that, for novice therapists there are a range of responses to FOI, with two poles on either end - inspiration and growth on one and avoidance and resignation on the other. These responses recall Carol Dweck’s research on “mindset,” which argued that more successful individuals exhibit a “growth” mindset in which they imagine that they are capable of improvement through effort, as opposed to “fixed” mindset individuals who believe that they cannot change (Dweck, 2008). What is interesting in the case of Theriault and Gazzola’s work is that these two mindsets were found to varying degrees in the same individuals, making feelings of incompetence in therapists a fascinating and complex area of study.

It is worth noting that while there is significant evidence that therapists struggle with feeling inadequate, there is also research on therapist attitudes that has found an opposite phenomenon: not feeling too helpless but instead feeling overconfident. For example, one study found that of 129 therapists interviewed, the average therapist rated their own performance in the 80th percentile, with 25% of therapists claiming to be in the 90th percentile or higher (Walfish et. al, 2012). This overrating of one’s ability is not only a phenomenon in therapists. An earlier, non-therapy related study, found that 80% of automobile drivers thought of themselves as above average, another statistical impossibility (McCormick, Walkey and Green, 1986). This phenomenon has its roots in the concept of “illusory superiority” (Hoorens, 1993) and was famously developed into

the Dunning-Kruger effect, a cognitive bias in which incompetent people lack the ability to recognize their own incompetence, leading them to overrate themselves (Dunning and Kruger, 1999).

This is an apparent contradiction - how can therapists struggle with feeling helpless while also thinking they are better than they actually are? One way to understand this is from a cognitive lens: therapists have an unrealistic sense of how competent they, or anyone, should be and then feel inadequate when they fail to meet the excessively high bar set by their irrational beliefs (Forney, Wallace-Schutzman and Wiggers, 1982; Schaufeli, Maslach and Marek, 2017). From a psychodynamic perspective, one might think of the contradiction in terms of defense mechanisms such as reaction formation, in which the therapist responds to feeling inadequate by behaving in the opposite manner (Baumeister, Dale, and Sommer, 1998).

In conclusion, while Thériault and Gazzola's work marks an inspiring and impressive beginning, there are some meaningful gaps in the area of FOI. To the best of the author's knowledge, few if any studies have examined feelings of incompetence within a session or entire psychological treatment, explored how these feelings relate to the actual therapy process from the client's perspective or examined how these feelings relate to outcomes like psychiatric symptom reduction or increased functioning. This dissertation begins to explore each of these questions while building on the existing literature about feelings of incompetence among therapists.

Countertransference

One way that researchers have attempted to measure and understand therapist feelings in the therapeutic process is through the construct of countertransference. This

section will highlight important ideas about countertransference and the implications for how those ideas can help to explain and explore therapist feelings of incompetence.

From early on in its conceptual life, countertransference has been a source of some controversy, beginning with how to define it. Broadly speaking, there have, until recently, been two camps when it comes to defining countertransference: classical and totalistic (Kernberg, 1965). Recent scholars have argued that these divisions are neither particularly stark nor helpful and argued for a third conception known as the "integrative conception (Hayes, 2004)." The classical understanding of countertransference is related to the idea of transference, the unconscious redirection of feelings towards the therapist that the patient typically has towards others. Freud first observed transference when he noticed that the patients he treated for hysteria developed intense feelings towards him that seemed completely incommensurate with a typical patient and doctor relationship (Freud, 1895). Freud's classical view of countertransference is that it is the unconscious reactions of the therapist to the patient's transference. Others such as Annie Reich[1], expanded on this classical understanding, writing that the patient "represents an object of the past onto whom past feelings and wishes [of the therapist] are projected (Reich, 1951)," though she explains that these projections are in direct reaction to the patient's pathology. Contemporaneous psychoanalytic theorists deepened the classical view to include the role of regression and identification and how these processes helped explain reactions in the countertransference (Fliess, 1953).

[1] Reich came by her wariness of countertransference honestly: she married and later divorced her first analyst, the psychiatrist, Wilhelm Reich, a sex-obsessed psychiatrist who studied with Freud and coined the term Sexual Revolution.

The classical understanding of countertransference led its proponents to advocate against making use of the countertransference in the treatment. The point was to “dominate” it (Freud, Jung and McGlashan, 1994), as Freud wrote in a letter to Carl Jung. In this understanding, the classicists fear that countertransference, being composed of such primitive emotional forces, would lead to breakdowns in the treatment. For example, Reich writes about an analyst who became “violently annoyed” with a patient whose transference led to aggressive behavior toward the analyst (Reich, 1951), meeting the therapist’s emotional needs instead of the patient’s.

According to the classical definition, it is possible to argue that therapists can feel incompetent unrelated to their countertransference. In this conceptualization, there would be countertransference feelings of incompetence and non-countertransference feelings of incompetence. For example, a therapist might generally lack confidence throughout their life. If that is the case, one can question whether that therapist feeling inadequate with a patient really has anything to do with the patient or the treatment at all. The challenge with trying to make this distinction is the same challenge with the classical concept in the first place, which is how to draw a line between countertransference feelings and non countertransference feelings (Kernberg, 1965). In fact, as Smith points, out, even Reich does not fully accept the narrow classical position she is famous for propogating (Smith, 2001). Due to this complexity, it is simpler to include all the therapist’s feelings towards the patient in the term countertransference.

While the classical understanding of countertransference attempts to erect a barrier between the therapist’s unconscious reactions to the patient’s unconscious and the “rest” of a therapist’s feelings towards a patient, the totalistic understanding of

countertransference removes this barrier to varying degrees (Kernberg, 1987). Heiman, most radically, suggests including any and all reactions of the therapist in the countertransference definition (Heimann, 1950). In this vein, Racker coined the term "indirect countertransference" to refer to therapist reactions to third parties involved in the treatment, such as a patient's parent or romantic partner (Racker, 1957).

Winnicott also had a broad understanding of countertransference, writing about an "objective countertransference," natural reactions of the therapist toward radical and often aggressive behaviors of patient (Winnicott, 1949). In other words, these reactions are not unique to a specific therapist but would be there for any therapist, just as there are understandable, universal "hateful" maternal reactions to their infants (Winnicott, 1949). Melanie Klein helped explain countertransference through the concept of projective identification, the way that patient's unconscious conflicts can inhabit the therapist. Building off Freud's idea of "projection," in which the patient attributes to others their own disavowed feelings, Klein argued that these feelings come to actually inhabit the therapist's unconscious (Klein, 1946). Later, R.D. Laing offered that, one person can unconsciously induce another to actually embody the first person's projection of them (Laing, 1962). Once one expands the definition of countertransference, it can become very broad, very fast, to the point that critics say it can lose meaning altogether.

Totalists instructed clinicians to use the countertransference to better understand the patient and tailor interventions accordingly (Kernberg, 1965). For example, intense countertransference early in a treatment is argued by some to be indicative of greater character pathology (Heimann, 1950). In this way, a therapist who can competently

identify the intensity of their countertransference can use this knowledge as a diagnostic tool. Taking this concept a step further, Sandler proposed that a meaningful countertransference reaction is not only useful, but also necessary in order for the patient to revisit conflictual earlier relationships (Sandler, 1976). That is, a patient can only work through their unconscious conflicts when they resurface as a result of a transference/countertransference process happening in the treatment.

Recent writing on countertransference has been more diplomatic, arguing that it is important to not get caught up in the classical/totalist debate, but to recognize some important lessons and commonalities amongst the different theorists: countertransference consists of both therapist and patient material (Gabbard, 2001) and therapists should work to understand their reactions to their patients and not act recklessly toward them (Gabbard, 1995). This perspective implies that therapists should think about countertransference as a lens through which to understand and manage behavior and interventions with their patients, without being dogmatic about the semantics of defining countertransference.

Frustration with totalistic and classical approaches has spawned a third definition of countertransference known as the “integrative” model (Gelso and Hayes, 2001), in which Hayes defined countertransference as “therapist reactions to clients that are based on the therapist’s unresolved conflicts (Hayes, 2004).” This definition is wider than Freud’s because it includes both conscious and unconscious reactions and these reactions can be to transferential or other material, but it attempts to identify the source of the therapist’s reactions as residing within the therapist. In this way, this definition is narrower than Heimann’s totalist and all-inclusive definition. Importantly, this

perspective puts the onus on the therapist to manage their reactions to the patient and not place the onus on the patient who is seeking therapy precisely because they cannot control the behaviors related to their conflicts. (Hayes, 2004).

In addition to theoretical understandings of countertransference, there is a growing body of experimental research on the subject. The earliest countertransference experimental efforts used q-sort methods (Fiedler, 1951) and evaluations by a therapist's colleagues (Cutler, 1958) to try and measure the degree to which therapists avoided certain patient material based on their own reactions. The latter study in particular focused on the primacy of avoidance as a therapist response to strong countertransference phenomena, which led to countertransference being "operationalized as avoidance behavior (Hayes, 2004)." A 2014 meta-analysis found that there were few studies conducted on countertransference in the 70s and 80s with a small increase in the 90s and large increase in the 2000s (Machado, 2014).

Unfortunately, there is considerable methodological critique of many of these early studies. Specifically, that way that countertransference studies were conducted for several decades, usually by or alongside Charles Gelso, was to use laboratory analogue methods in which therapists were exposed to client-actresses with an assortment of presenting problems (Yulis and Kieser, 1968; Peabody & Gelso, 1982; Hayes and Gelso, 1991). Researchers in one study that used this method found that state anxiety in therapists predicted countertransference behavior, again, operationalized as avoidance, though only for male therapists (Hayes and Gelso, 1991). The problem with this method is that researchers found that different therapists had different reactions to supposedly objective stimuli and more importantly, the analogue

was too different from therapy and therefore too artificial to be an appropriate analogue (Hayes, 2004).

Researchers have developed over a dozen instruments to measure countertransference, both qualitative and quantitative, and often using a likert scale, and often using a list of feelings for therapists to rate after a session with a patient (Machado, 2014). Betan and Weston developed the empirically valid and reliable "Countertransference Questionnaire" for this purpose (Zittel and Westen, 2003). Their scale is administered to a therapist directly after a session and consists of eight factors, including "Helpless/Inadequate" - which for the purposes of this dissertation will be used to measure feelings of incompetence. There will be a more detailed description of the measure in the Methods section. Indeed, the countertransference questionnaire scale was used in study by Betan and Westen, which found that therapist countertransference reactions were associated in "predictable" ways with specific personality pathology (Betan and Westen, 2005). Other examples of countertransference measures include the REACT scale, which measures therapist emotional reactions to substance abusers (Najavits et. al, 1995) and the Feeling Words Checklist (Whyte, Constantopoulos, & Bevans, 1982), which has gone through several expansions and revisions and uses self-report ratings of emotional words to measure countertransference feelings. These and other measures are important attempts by researchers to quantify a concept - countertransference - that is simultaneously contentious in definition and vitally important to understanding the therapist's role in psychotherapy.

In conclusion, this dissertation argues that countertransference theories can help explain therapist feelings of incompetence. There are competing definitions of

countertransference as well as competing theories on how therapists should use or not use the information it provides in the treatment. While these debates might point to difficulties in using countertransference as a way of measuring feelings of incompetence, research from the last few decades demonstrates the development of increasingly sensitive and useful countertransference measurement techniques. By looking at feelings of incompetence as a countertransference phenomena, one can understand the feelings of incompetence as being made up of a mix of the therapist's own internal conflicts as well as, to a degree, identification with the patient's unconscious conflicts. In sum, the simultaneous flexibility and complexity of countertransference makes it an effective construct for thinking about and measuring therapist feelings of incompetence.

Therapeutic Alliance

So far this paper has focused on therapist feelings of incompetence and how to conceptualize and measure them, namely through the use of countertransference theory and measurement. A key reason to study therapist feelings of incompetence is to learn how these feelings relate to the therapeutic process and ultimately the treatment outcome. This section will focus on part of the process, the therapeutic alliance: its history, how to define and understand the alliance theoretically and how the quality of the alliance might be connected to countertransference phenomena.

Like many major concepts and constructs in psychotherapy, the therapeutic alliance has its origins in Freud's writings on transference. Freud initially argued that a positive relationship between therapist and patient was likely the result of a positive transference, yet he also wrote that "It remains the first aim of the treatment to attach

him [the patient] to it and to the person of the doctor (Freud, 1913).” This tension between transference and a non-transferential working alliance continued through the years. Still thinking in terms of transference, Elizabeth Zetzel coined the term “therapeutic alliance” in her essay on “Current Concepts of Transference,” to refer to the part of the therapist patient relationship not beset by transference phenomena (Zetzel, 1956). In an essay a decade later, Ralph Greenson wrote for the first time about a “working alliance” that he defined as a “relatively nonneurotic, rational rapport which the patient has with his analyst” and which “deserves to be recognized as a full and equal partner in the patient-therapist relationship (Greenson, 1965).”

Brenner argued that there was no meaningful difference between the working alliance and the transference since all aspects of the relationship between patient and therapist are infused with transference phenomena (Brenner, 1979). He insists that psychoanalysis should be focused primarily on interpretation and implies that a preoccupation with forming a strong alliance can actually get in the way of an effective analysis. A preoccupation with an alliance might both obscure maladaptive transference phenomena from other places in the patient’s life as the therapist might mistake these repetitions for the alliance, especially if they appear as friendliness or compliance (Safran and Muran, 2006). While Brenner’s critique is well noted, his objections could not stop the concept of an alliance from becoming a non-controversial and increasingly key part of the discourse around psychotherapy process.

Bordin, in the same year as Brenner’s rhetorical attack on the concept, helped expand the concept from its psychoanalytic roots to be considered important in myriad modalties, writing that “the working alliance between the person who seeks change and

the one who offers to be a change agent is one of the keys, if not the key, to the change process (Bordin, 1979).” In addition to expanding the use of the construct to non psychoanalytic modalities, he defined the working alliance in terms of three components: goals, tasks and bonds. In his definition, a strong alliance consists of agreement on goals, the tasks instrumental to achieving the goals and the trust necessary to sustain cooperation between therapist and patient.

In this author’s opinion, Bordin’s definition, the basis for the working alliance measure used in this paper, is broad enough to include both the psychodynamically oriented conceptions of Zetzel, Greenson and Gelso, while also making space for more cognitive, behavior and other potential definitions of a working alliance. One could argue that it even makes space for Brenner’s orthodox objections, as it does not rule out that the whole relationship could be built on transference, but simply avoids this issue by not emphasizing whether the collaboration between therapist and patient happens on a conscious or unconscious level (Safran and Muran, 2001).

There is some dispute about the extent to which an alliance can change over the course of a treatment or indeed, whether it matters if the alliance changes. Some argue that like all relationships, the therapeutic relationship is kinetic, changing in quality over the course of a treatment (Horvath, 2005). Indeed, researchers have conceptualized these changes in terms of ruptures and repairs (Safran et. al, 2001) or, to use slightly different language, in terms of development and decay (Horvath and Marx, 1991). One recent study found that “the most robust predictors of session outcome are within-treatment changes in patient reports of the alliance (Zilcha-Mano et. al, 2016),” implying that changes in alliance over the course of treatment informs the outcome.

One way to understand this potential tension is to think of the alliance occurring in two distinct phases - an initial phase peaking around the 3rd session which focuses on goal agreement and basic cooperation - and a second phase which involves the therapist naming and often challenging patient thoughts, feelings and/or behavior, with ruptures and ideally, repairs, along the way (Ardito and Rabellino, 2011). In this vein, one study of brief psychotherapy found that alliance ratings were consistently stronger in the beginning and end of treatment but that there was a dip in the middle (Golden and Robbins, 1990). In this way of thinking, the early establishment of the alliance is necessary but not sufficient for a successful outcome. It also implies that early alliance ruptures might be more disruptive than later ones, which would be more easily repaired after an initial alliance was established.

Why has the alliance received so much attention in the last few decades? Safran and Muran, themselves major proponents of alliance-focused psychotherapy, have asked this question, given that the alliance accounts for approximately 6% of the treatment outcome (Safran and Muran, 2006), a meaningful, but by no means overwhelming effect. Furthermore, they point to questions about whether the alliance itself is therapeutic or whether it merely correlates with outcome improvements. If the latter is the case, it is also possible, as some researchers have found, that the outcome, or symptom improvement, predicts the alliance (Puschner, Wolf and Kraft, 2008), instead of the other way around. Other studies have found the opposite, like a session-by-session study that found that previous session alliance ratings predicted next session symptom improvement (Falkenström, Granström and Holmqvist, 2013).

Additionally, a meta-analysis from a decade earlier demonstrated that alliance quality predicts treatment outcome (Martin et. al, 2000).

Responding to those who raise questions about the utility of the alliance as a construct, Sigal Zilcha-Mano writes, in an essay entitled, “Is the Alliance Really Therapeutic?” that there are two different components of the alliance - a trait alliance which is based on patient personality and a state alliance which involves changes in the capacity of the patient to form alliances (Zilcha-Mano, 2017). She shows how changes in the state-like part of the alliance can predict symptom improvement, independent of the trait-like, initial capacity to form alliances. One might speculate that it is in the second, state-like, phase where a therapist’s skills or personality come into play, since the first trait-like phase of the alliance depends more on the personality of the patient and the benignity of the therapist. In sum, there is significant evidence that the working alliance, perhaps how it connects to an individual’s capacity for healthy relationships, contributes to symptom improvement. Similarly, some therapists have been shown to use the alliance to facilitate healing and growth in patients (cite).

The Relationship Between Countertransference and the Therapeutic Alliance

As described in the previous section, one area of research that focuses on what the therapist brings to the relationship with the patient is countertransference. There has been some research about the intersection of countertransference characteristics and the working alliance, with a 2014 literature review finding three studies (Machado, 2014). The results of these studies have varied. One found a negative correlation between extreme countertransference feelings and alliance strength (Ligiéro and Gelso, 2002), while another found that positive feelings like trust and curiosity in the

countertransference were positively associated with patient alliance ratings (Dahl et. al, 2012). Another focused on cocaine addicts and found only a weak relationship between positive countertransference feelings and patient-rated alliance strength (Najavits et. al, 1995). A Brazilian study published in 2015 focusing on countertransference, alliance and defense mechanisms, found a moderate negative correlation between therapist feelings of distance (a domain that includes “discomfort, mistrust, boredom, rejection, despair, reproach, accusation, irritation, fear and hostility”) and patient ratings of alliance strength (Machado et. al, 2015). An unpublished 2019 master’s thesis focused on gender matching, countertransference, alliance and outcome, found no correlation between countertransference and the therapeutic alliance (Visser, E. 2019).

While not explicitly “countertransference” focused, there have also been studies on how therapist behaviors might be associated with the therapeutic alliance. One study found that client session ratings were positively correlated with feelings of therapist confident involvement and negatively correlated with therapist distraction (Saunders, 1999). This is relevant to this dissertation because one behavior predicted with therapist feelings of incompetence is withdrawal or distraction. In their review a few years later, Ackerman and Hilsenroth found that therapist personality characteristics like “being flexible, honest, respectful, trustworthy, confident, warm, interested, and open were found to contribute positively to the alliance (Ackerman and Hilsenroth, 2003).”

Psychotherapy Outcome Measurement

Finally, it is worth a brief word on psychotherapy outcome measurement, as this will be one of the constructs examined in this study. This section will not only broadly

summarize the research on psychotherapy outcomes, but also review the theoretical assumptions underlying the commonly used measurements of patient progress.

One assumption is that patient progress can be measured at all. On the contrary, perhaps there is something improvisational and artistic about psychotherapy - like dancing or making music with someone - that makes judging a successful treatment, like judging a great album by a musician, a matter of taste (Storr, 2012). Sure, one could make an objective rubric for choosing The Beatles' best musical output, but would it convince anyone who didn't already enjoy that unique combination of musical notes and rhythms? Probably not. You can say *Abbey Road* and I can say *Rubber Soul*, and no chart measuring popularity or lyrical complexity will be able to make either of us change our minds. Freud, himself a scientist by nature who certainly tracked symptoms such as little Hans' equinophobia or Dora's aphonia, also cautioned against scientific ways of thinking about therapeutic processes. He writes:

> It is not a good thing to work on a case scientifically while treatment is still proceeding - to piece together its structure, to try to foretell its further progress...Cases which are devoted from the first to scientific purposes and are treated accordingly suffer in their outcome; while the most successful cases are those in which one proceeds, as it were, without any purpose in view, allows oneself to be taken by surprise by any new turn in them (Freud, 1912).

Freud implies that a scientific and structured approach actually gets in the way of doing good psychotherapy. And yet, there is *still* utility in trying to measure psychotherapy outcomes, since, unlike jazz - except in the rhetorical sense, psychotherapy can save or not save a life. Even Freud concedes in the section quoted above that there can be a "successful" "outcome" and "progress" however one might want to measure them (Freud, 1912).

But how to measure a treatment outcome? Michael Lambert, father of the Outcome Questionnaire, the standard in psychotherapy outcome measurement, writes that in an ideal world, determining an outcome would involve integrating "numerous measures of patient's subjective discomfort, clinician ratings, trained observer ratings, physiological indices and environmental information (Lambert et. al, 1996)." In other words, truly valid and reliable psychotherapy outcome measurements would be highly complex with diverse input. However, the pragmatic concerns of being a clinician with multiple patients per day in addition to obligations such as research or teaching or a host of other responsibilities, make the holistic measurement approach more dream than reality (Lambert et. al, 1996). Many attempts have been made to design outcome measures that can capture some holistic essence of patient progress while still being concise enough to be practical to administer regularly, with over ten different systems reviewed in a recent paper on popular outcome measurement systems (Drapeau, 2012). Two of the most popular systems are the Partners for Change Outcome Management System (PCOMS) and the Outcome Questionnaire Psychotherapy Quality Management System (OQ), which together demonstrate the tradeoffs between detail and efficiency (Miller, Hubble, Chow, and Seidel, 2015), with the former a short, four question measure that minimizes session disruption and the latter, relying on a 45 question measure, which provides more depth but takes longer for patients to fill out and therapists to analyze. In sum, outcome measures can be designed in a variety of ways and, while always imperfect, can be employed differently depending on the clinical and research situation.

While the aim of this dissertation is not to prove that outcome measurement is useful in psychotherapy treatments, it is worth noting the positive contribution of routine outcome monitoring, since therapists in the study used for this dissertation were given regular feedback about patient outcomes and alliance strength. On this topic, there is a plethora of research showing the positive effects of routine outcome measurement in improving therapeutic outcomes (Shimokawa, Lambert and Smart, 2010; Miller, Hubble, Chow, and Seidel, 2015). Going back to Freud (1912), theoreticians have explained this quite simply: a strong alliance compels patients to comply with therapeutic interventions or, put more gently and passively, encourages patients to allow themselves to be helped (Crits-Christoph et al., 2011). From a less quantitative and more psychoanalytic perspective, Owen Renik has written compellingly about the imperative for psychoanalysts to monitor outcomes (Renik, 2012). He writes, “I consider the insight that a patient gains in a successful clinical analysis very important—-but as a means to an end: the end of providing the patient with, in his or her judgment, less distress and more satisfaction in life (p 235-6).” Across the modality spectrum, in other words, there is robust support for a patient centered focus on treatment outcomes, both as measurable (if imperfectly so) and relevant.

Helpfully complicating this idea, Jonathan Shedler argues that outcomes do matter and can be monitored, but that many studies, especially those using randomized control trials (RCTs), do not accurately mirror the actual therapeutic experience of therapists and patients (Shedler, 2010). Furthermore, he emphasizes the importance of lasting and sustainable change in patients which is not often captured by studies that

monitor patient progress at termination but not a year later. It is a limitation of this study that no longer term measurements are made to confirm the outcomes.

Current Study

As established above, therapists across all modalities, levels of experience and demogaphics contend with self doubt. This study asks, to what extent are therapists able to form relationships in order to help their patients heal and grow in the face of this self-doubt? If self-doubt is a major impediment, one might imagine various ways for training centers or therapists, themselves, to address their feelings of incompetence. If these feelings are not associated with weaker alliances and poorer outcomes, perhaps they are a sign of therapists who are simply more aware of their own room for growth and therapists should be taught to actively use their self-doubt as way of improving their work. There have been some exploratory studies on the existence of feelings of incompetence in therapists, but none that attempt to quantify the relationship between such feelings and alliance or outcome. Given the gaps in the literature when it comes to measuring the effects of therapist feelings of incompetence on the therapeutic relationship and on the patient's outcome, this study is warranted and offers meaningful benefits to therapists.

Specific Aims:

1. Determine the association between therapist feelings of incompetence (FOI) as reported by the therapist, the working alliance (WAI) and the change in total OQ (OQ) score as reported at each session by patient.

2. To determine the causal relationship between the feeling of incompetence of the therapist, the change in the working alliance and the change in outcome questionnaire.

3. To discuss the relationship between FOI, the working alliance and the outcome change in the context of session video observations.

Chapter 2: Methods

Data Collection:

The data used in this study was collected from the Therapeutic Alliance Assessment Project (TAAP), an ongoing psychotherapy research project that is part of the INTERSECT lab at The Psychological Center at the City College of New York (CCNY). The Psychological Center is an outpatient training clinic that serves children and adults in New York City as well as residents of surrounding communities in New York, New Jersey and Connecticut. It is staffed by doctoral students who are studying in the clinical psychology program at CCNY and provides low-fee psychotherapy, group psychotherapy and neuropsychological assessments.

The INTERSECT lab is a clinical and epidemiological research program that broadly examines the intersection of mental health outcomes and life course stressors in a marginalized urban population. Dr. Sasha Rudenstine, PhD, directs the lab, which is housed at CCNY and staffed by doctoral students.

TAAP is a short-term psychotherapy research program that provides therapy to help adults who are struggling with their emotions, their relationships, and/or navigating changes in life circumstances. It consists of 20 sessions: 2x week for the first eight weeks then 1x week for four more weeks. It was approved by the Institutional Review Board (IRB) at CCNY and has been active since 2019. Deliberate practice and feedback inform the clinical work in several ways. First, both therapists and patients complete self-report measures at every session that assess process and outcome related variables including the therapeutic alliance, psychological well-being, daily stressors. Second, all sessions are video-recorded and reviewed in clinical supervision. Specifically, the results from the session measures, in conjunction with the video recordings of the session, guide the supervision, which is provided by a licensed clinical psychologist. 8 cases were analyzed for this study with median treatment length of 20 sessions (mean=18.75, SD= 1.92).

Participants:

Patients:

The participants are patients at the Psychological Center, recruited largely from referrals from local and regional mental health practitioners in private practice and at hospitals, clinics and schools. At the Psychological Center, patients first go through an initial screening process of a thirty-minute interview with a training clinician, before being matched with a therapist and treatment modality. Prospective adult patients were given the option to participate in TAAP or receive the standard model of care at The Psychologcal Center (i.e. long-term psychotherapy). Informed consent to participation in

TAAP was obtained from therapists and patients and included consent to complete research measures at each session and video recording of all sessions.

This study included 1 male identified patient and 7 female identified patients (N=8), ranging from 20 to 59 years of age (M=31.71 SD=12.57) and whose ethnic and racial identities included white (62.5%), latino/hispanic (25%) and other (12.5%)**.** All TAAP patients completed a TAAP specific intake process conducted over two sessions. In the first session, an intake therapist conducts an interview covering patient history, presenting problems and patient relationships. In the second session, the intake therapist administers The Mini-International Neuropsychiatric Interview (M.I.N.I, Sheehan et al., 1998). Patients included in the study received the following diagnoses[2]: general anxiety disorder (n=3, 37.5%), major depressive disorder (n=3, 37.5%) persistent depressive disorder (n=2, 25%), panic disorder (n=1, 12.5%), Personal History of Self-Harm (n=1, 12.5%) and Other Specified Depressive Disorder (n=1, 12.5%).

Therapists:

The 5 therapists in the study are doctoral students in the clinical psychology program at CCNY. They include 1 male identified therapist and 4 female identified therapists. Therapists ranged from 2nd year to 4th year doctoral students, ranged from 29 to 57 years old (M=39.2 SD=10.54) and ethnically identified as white (80%) and other (20%). Therapists attended a weekly group supervision that was overseen by a licensed clinical psychologist.

[2] Several patients received more than one diagnosis

Procedure:

Treatment and Supervision:

The treatment provided by TAAP therapists is a short-term alliance focused modality influenced by Time-limited Dynamic Psychotherapy (TLDP; Levenson, 2004), Brief Relational Treatment (BRT; Safran, 2002), and Alliance-Focused Training (AFT; Eubanks-Carter et al., 2015). The following paragraphs give a brief description of each before turning to how TAAP looks in practice.

TLDP is a treatment modality pioneered by Dr. Hanna Levenson that integrates object-relations theory, attachment theory and experiential learning to help patients recognize and change dysfunctional relational patterns towards others and toward the patient, themself (Levenson, 2004). Levenson proposed that by having patients experience and observe their maladaptive relational behaviors within the relationship to the therapist, they would be able to ultimately observe and then alter these behaviors in their life outside of the therapy room.

BRT is a treatment modality pioneered by Dr. Jeremy Safran and colleagues that focuses on the here and now of the therapeutic process as well as encouraging countertransference disclosures and therapist self awareness, in the service of repairing ruptures in the therapeutic alliance (Safran, 2002). BRT advocates reminding patients of the time limited nature of the treatment as a way of prompting expressions of patient feelings about the therapy.

Alliance-Focused Training is an instructional method that emphasizes teaching therapists better “self-awareness, affect regulation, and interpersonal sensitivity” (Eubanks-Carter et al., 2015) with the goal of helping therapists tolerate alliance

ruptures. The authors suggest three ways to help therapists develop these skills in the context of conducting therapy. First, video recordings of ruptures are observed repeatedly and analyzed during supervision - this builds self-awareness. Second, therapists and supervisors engage in role-plays aimed at recreating ruptures that occurred during the observed session in order to spark curiosity about the patient's experience that can lead to increased interpersonal sensitivity. Third, mindfulness exercises can help further develop therapist self-regulation that builds up tolerance for the discomfort of in-session ruptures.

After a screening interview with a doctoral student in the clinical psychology program, TAAP patients attend two intake sessions with a TAAP therapist: one more open ended and one, the M.I.N.I (Sheehan et al., 1998), a formal interview focused on psychiatric symptoms. If the patient is deemed suitable for TAAP based on the intake, a different TAAP therapist then conducts therapy with the patient - eight weeks of two sessions a week and four weeks of once-a-week sessions, adding up to 20 total sessions. The pacing of the treatment is designed to help therapist and patient to form a working alliance more quickly in the early stages of treatment while also allowing a more gradual and healthy transition into life after treatment. The TAAP treatment model incorporates elements of TLDP, such as recognizing relational patterns to others and oneself and focusing on the relationship between patient and therapist, as well as elements of BRPT, such as turning the therapist's focus to moments of breakdown in the alliance and emphasizing countertransference awareness, though not always disclosure, in the session. A typical session might consist with the therapist and patient reviewing patient data on their well-being, transition into a more typical psychodynamic

therapy session with patient and therapist connecting present day experiences, behaviors and emotions with past ones, before therapist interventions that focus on ruptures, even mini-ones, in the here and now relationship between therapist and patient. At the end of the session both therapist and patient fill out measures related to the session that just took place.

In terms of supervision, TAAP draws on AFT heavily, using video recordings from each session, often viewed at random moments, to identify ruptures and then role-play the moment in supervision, itself. TAAP supervision integrates these rupture observations and role-plays with data from session measures, described in the following section. A typical supervision session might begin with reviewing data for a specific patient, then watching video recordings of a recent session. The supervisor would then pause the video when they observe a rupture or avoidant moment, socratically encouraging therapists to try and understand what is happening in the relationship at that moment. Finally, therapists will role play moments from the session under the guidance of the supervisor who will act almost like a theater director in advising the therapists. Similarly to AFT, these practices build self-awareness, emotion regulation and sensitivity to ruptures in the therapeutic relationship.

Measures:

Countertransference Questionnaire (CTQ; Zittel & Westen, 2003): The CTQ, which therapists filled out immediately after every session, is an empirically valid and reliable measure consisting of 79 items that ask therapists to rate items/statements about how they feel and/or act toward their patient on a scale of 1 to 5 (1 = not true at all; 3=somewhat true; and 5=very true). Examples of items include: “I feel resentful

working with him/her," "I feel incompetent or inadequate working with him/her," and "I like him/her very much." The authors proposed dividing the items into eight factors with 25 items that did not load strongly on any single factor. The factors are: Overwhelmed/Disorganized, Helpless/Inadequate, Positive, Special/Overinvolved, Sexualized, Disengaged, Parental/Protective and Criticized/Mistreated. This study used the 8 item Helpless/Inadequate factor to measure therapist feelings of incompetence in the countertransference and the cronbach's alpha for the 8 items was $\alpha = .89$. The items are listed in the appendix.

Working Alliance Inventory (WAI; Horvath & Greenberg, 1989): The WAI is a 12-question patient self-report measure that TAAP patients filled out immediately following every session. Patients answer questions on a scale from 1 to 7 about their relationship with the therapist. The questions are divided into three factors reflecting Bordin's conceptualization of the alliance consisting of goals, tasks and bond. Examples of items include, "My therapist and I agree about the things I will need to do in therapy to help improve my situation" and "I believe my therapist likes me." In this study, the cronbach's alpha for the 12 items was $\alpha = .88$.

Outcome Questionnaire 45.2 (OQ-45.2; Lambert et al.,1996; Boswell et al., 2013): The OQ-45 contains 45 items that ask the patient to reflect on the time between sessions and rate items on a 5 point likert scale from 0, "Never" to 4 "Always." Examples of items include critical items like "I have thoughts of ending my life," as well as items like "I get along well with others," "I have too many disagreements at work/school" and "I have sore muscles." The OQ responses are broken down into a three-factor structure assessing Symptom Distress, Interpersonal Relations, and Social

Role. This study measured patient well-being and progress by calculating the change in patient OQ scores between sessions. The 45 items had a Cronbach's alpha score of α = .88.

Statistical Analyses:

This study used correlational analyses, linear regression, and stratified regression to examine the relationship between therapist feelings of incompetence as measured by the CTQ Helpless/Inadequate factor, working alliance as measured by the WAI and patient outcome as measured by the between session difference in OQ scores.

Linear correlational analyses were used to determine Pearson correlation coefficients for the relationship between FOI and WAI, FOI and OQ change to next session, and WAI and OQ change to next session. Linear and Multi-linear regression analyses were then used to test if FOI and WAI significantly predicted OQ change.

Since FOI and WAI were highly correlated, stratified regression analysis was used to determine which model better explained the causal relationship. We followed the causal inference method described in Frangakis and Rubin's "Principal Stratification in Causal Inference (Frangakis & Rubin, 2002)." We examined the relationship between the change in WAI and change in OQ for fixed levels of FOI before the corresponding therapy session, and the relationship between the FOI after the corresponding therapy session and change in OQ for fixed levels of change in WAI. To get fixed levels of FOI and change in WAI, we stratified by finding 7 levels giving equal number of samples per

bin. This allowed us to examine the effect of WAI on OQ change when controlling for FOI as well as the effect of FOI on OQ change when controlling for WAI.

Chapter 3: Results

This study examined the associations between therapist feelings of incompetence (FOI), the patient reported working alliance (WAI) and the change in patient reported outcome (OQ). Next, it determined the causal relationship between the therapist's FOI, the change in WAI and the change in OQ. Finally, it will discuss the above relationships through the lens of clinical material obtained in session transcripts.

Aim 1. Determine the association between therapist feelings of incompetence (FOI) as reported by the therapist, the working alliance (WAI) and the change in total OQ (OQ) score as reported at each session by patient.

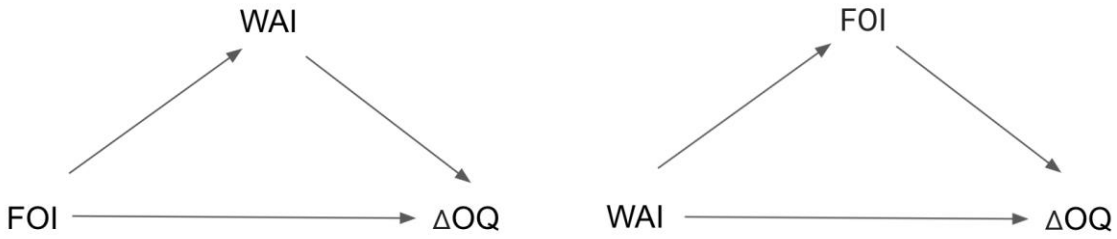
Correlational analyses showed that therapist FOI is positively correlated with the change in OQ, $r(131) = .379$, $p < .001$, that therapist FOI is negatively correlated with patient reported WAI, $r(131) = -.330$, $p < .001$ and that patient reported WAI is negatively correlated with change in OQ, $r(123) = -.26$, $p<.001$ (Table 1). In other words, higher therapist FOI is correlated with a decrease in functioning as measured by the OQ and a weaker therapeutic alliance as measured by the WAI, while a stronger working alliance is positively correlated with an increase in functioning.

Multiple linear regression analysis was used to test if FOI and WAI significantly predicted changes in OQ. The results of the regression indicated the two predictors explained 31% of the variance ($R2 =.306$, $F(2,131)=28.21$, $p<.01$). It was found that FOI significantly predicted change in OQ ($\beta = .224$, $p=.005$), as did WAI ($\beta = -.439$, $p<.001$). The two variables, FOI and WAI, are highly correlated and the regression did not disentangle their effects on OQ (Table 2).

Aim 2. To determine the causal relationship between the feeling of incompetence of the therapist, the change in the working alliance and the change in outcome questionnaire.

To determine which causal model better explained the variance in the change in OQ, two models were compared using stratified regression analysis. In Model 1, therapist WAI mediates the relationship between Therapist FOI and change in the OQ while in Model 2, therapist FOI mediates the relationship between the change in WAI and change in OQ.

Two models for the relationship between therapist FOI and working alliance on change in OQ



Model 1.
WAI mediates the relationship between FOI and Change in OQ

Model 2.
Therapist FOI mediates the relationship between WAI and change in OQ

From the stratified regression analysis, we concluded that Model 1 is more representative of the data than Model 2 (Table 3, Figures 2 and 3).

The correlation coefficients between change in WAI and change in OQ for fixed level of FOI exhibit higher variance (Table 3) than the regression coefficients between therapist FOI and change in OQ for fixed level of change of WAI, showing that the relationship between FOI and change in OQ strongly depends on the change in WAI. Furthermore, the mean of the regression coefficients for WAI on OQ, controlling for FOI, are significant (p=.05) while they are not significant for FOI on OQ controlling for WAI (p=.16). Thus, we can conclude that the effect of change in WAI on FOI is predominant on the effect of FOI on the change in WAI when it comes to driving change in OQ.

Because the direct effect between FOI and OQ change is not significant, while the Mediator-specific effect (WAI on OQ) is significant, we can conclude that FOI drives the OQ change almost entirely through the change in WAI. Furthermore, because the FOI specific effect is not significant on OQ change, while the Direct Effect of WAI on OQ change is significant, we can conclude that OQ change is driven by WAI change directly and FOI, acting as a mediator, does not have significant effect on OQ change.

Aim 3. To discuss the relationship between FOI, the working alliance and the outcome change in the context of session video observations

Careful review of session videos from sessions with high change in FOI and WAI suggests that there is a way that therapist FOI, triggered by powerful patient emotions, relates to therapist behaviors that disrupt the alliance. The discussion section will explore these results in far greater depth.

Chapter 4 Discussion

This dissertation set out to explore the meaning and impact of therapist feelings of incompetence (FOI) in short term psychodynamic psychotherapy. By examining the relationship between FOI and the working alliance and therapeutic outcome, the study hoped to discover what role these common therapist feelings played in key elements of the therapeutic process. To the best of the author's knowledge, while there has been extensive literature on the relationship between alliance and outcome, there has been comparatively little on therapist FOI that looks at specific treatments while using quantitative data to measure this construct's importance. This study examined therapist FOI through studying: First, the association between therapist FOI, the working alliance and treatment outcomes; Second, the causal pathway between therapist FOI, the working alliance and treatment outcomes and; Third, the qualitative themes that emerged in relation to the associations between FOI, the working alliance and treatment outcomes.

This discussion section will first present the quantitative results, in context with previous research. Subsequently, this section will place the results in the context of psychological theory and illustrate how these theories might explain the results with case examples and transcripts. The chosen clinical anecdotes, while neither conclusive nor based on a coding system, add texture and flavor to the empirical findings as well as the psychological theories. Finally, this discussion will explore the findings in terms of their implications for psychotherapy practice and training while also identifying and examining the key limitations of the study.

To summarize the results explicitly: the results tell us that higher therapist-reported feelings of incompetence are correlated with weaker working alliances and worse patient functioning. Furthermore, when examined more closely, the therapist's FOI do not impact patient functioning *directly*, but only *through* their impact on the working alliance - which then directly impacts the patient's functioning. In the qualitative section, I venture, with select case transcripts as evidence, that the relationship between therapist FOI and alliance can be understood such that increased therapist FOI in the face of patient distress can lead the therapist to emotionally withdraw from the patient which harms the working alliance and consequently the patient's functioning).

The association between therapist FOI, the working alliance and treatment outcomes.

This study hypothesized that there would be significant correlations between FOI, working alliance and session-to-session outcome change such that FOI would be negatively correlated with working alliance and outcome, while working alliance and outcome would be positively correlated (Aim 1). The results confirmed the hypotheses above.

First, correlational analyses showed a statistically significant, negative relationship between therapist FOI and the working alliance such that a higher therapist FOI was correlated with a lower working alliance. These findings are consistent with previous research. Anecdotal case study examples (Strean, 1993) and self-reported quantitative findings related to premature terminations (Brady, Guy, Poelstra, & Brown,

1996) support the finding of a significant association between the two variables. Thériault and Gazzola found in several studies that therapist behavior changed in response to their FOI, including avoiding longer term work, emotional disengagement in terms of negative impact and increased curiosity about the treatment and seeking more supervision in terms of positive impact (Thériault and Gazzola, 2005; Thériault, Gazzola and Richardson, 2009).

Related to the broader relationship between transference phenomena and the alliance suggested by this study, Brenner argued that the alliance was not meaningfully different from transference phenomena (Brenner, 1979). Furthermore, the findings from this study confirm the results from a study that found that positive feelings like trust and curiosity in the countertransference were positively associated with patient alliance ratings (Dahl et. al, 2012). In summary, the findings confirm and expand upon the previous research findings that more negative countertransference reactions, which would include the feelings of incompetence that this dissertation focused on, are associated with a weaker alliance and poorer outcomes.

Second, similar to past research, this study found a statistically significant correlation between therapist FOI and treatment outcome such that higher therapist FOI was associated with worse outcomes in the time between sessions. A 2011 meta-analysis of ten studies examining countertransference and outcomes, found a modest but statistically significant inverse relationship between countertransference feelings, generally, and patient outcomes (Hayes, Gelso, & Hummel, 2011). While not specifically about FOI, this meta-analysis provides a context for a specific countertransference feeling within wider set of countertransference feelings.

Third, the analyses showed a statistically significant relationship between the working alliance and treatment outcome such that better alliances were associated with better outcomes. The finding on the relationship between alliance and outcome is consistent with widespread findings about the relationship between these two variables. Safran and Muran found that the alliance accounts for approximately 6% of the treatment outcome (Safran and Muran, 2006) and meta-analyses confirm the significant relationship (Martin et. al, 2000). Multiple studies have found that alliance quality predicts treatment outcome across a variety of treatment modalities and clinical issues (Martin et. al, 2000; Castonguay, Constantino & Holtforth, 2006). Complicating this finding are several studies which have found causal pathways in both directions with some confirming the alliance predicts the outcome (Falkenström, Granström and Holmqvist, 2013) while others found that outcome predicts alliance strength (Puschner, Wolf and Kraft, 2008).

The causal pathway between therapist FOI, the working alliance and treatment outcomes

Expanding upon the preliminary findings described above, linear regression analyses found that together, therapist FOI and patient-rated working alliance, explained approximately 30% of the change in outcome between therapy sessions. However, because therapist FOI and the working alliance were highly correlated, it was important to determine which of these two variables, or both equally, drove the change in outcomes (Aim 2). To answer this question, two models for understanding how FOI and the working alliance affected change in outcomes were tested. In Model 1, FOI is a pathway between the working alliance and change on OQ. In Model 2, working alliance

mediates the relationship between therapist FOI and change in OQ. This study found that Model 2 was statistically significant, while Model 1 was not. Stated differently, therapist FOI did not explain change in OQ independent of the working alliance. Indeed, we can conclude that FOI drove the change in OQ almost entirely *through* the change in the working alliance. Furthermore, these findings suggest that change in OQ is closely related to change in working alliance irrespective of FOI.

One framework that helps to explain this finding is the 'common factors' literature. 'Common factors' refer to the theory that modality-specific elements are far less impactful on patient outcomes than therapeutic elements that are shared across treatment modalities, such as the working alliance or the expectation of improvement. Based on this idea, some psychologists advocate for a focus on these common process elements in their treatments, especially the working alliance (Wampold, 2015). The following section will delve into what psychological theory can tell us about the "why" of these relationships.

While there have been studies examining therapist FOI in quantitative, qualitative and theoretical ways, the results from this study are, to the best of the author's knowledge, among the first to document a significant quantitative association between therapist FOI and patient-rated working alliance as well as FOI and patient outcomes. To further underline the import of these findings: while other research has focused on the impact of FOI on *therapists*, less is understood regarding how FOI impacts the *treatment* and/or the *patient*. This study represents a step forward in that direction.

These results make sense alongside the literature reviewed in the previous aim. Namely, these results confirm previous studies showing that feelings in the

countertransference are related to the strength of the working alliance (Dahl et. al, 2012) and that the strength of the working alliance can explain a meaningful part of the patient's outcome change.

Aim 3: The relationship between FOI, the working alliance, and the outcome change in the context of session video observations

Results in the Context of Theory and Practice

In the previous parts of the discussion section, I have highlighted the quantitative ways that therapist FOI is related to both the working alliance and the outcome of the treatment. Specifically, both therapist FOI and the working alliance help explain treatment outcomes while also being inversely and significantly associated themselves, with FOI impacting symptom change indirectly, through the working alliance. Experiential avoidance and mirroring/reformulation are two possible windows, theoretically speaking, into how the data translates into the psychotherapy process of a session. I will explore these theories, connect them to the results and then illustrate them through clinical moments captured in transcripts from sessions. These moments were chosen because they occurred in sessions in which the quantitative results showed large changes in FOI and WAI.

First, I will examine moments illustrating how experiential avoidance, possibly in the context of therapist FOI, might relate to therapist responses that weaken alliances. Second, I will discuss moments in which therapists reformulated and mirror their patients during sessions in which a stronger working alliance was reported by the

patient and a decrease of FOI by the therapist. To be clear: this discussion seeks to highlight areas that warrant systematic investigation to more fully understand the moment-to-moment relationship between FOI and working alliance during psychotherapy sessions; the examples provided are not conclusive evidence for or against a correlational or causal link between FOI and alliance or outcome change.

Experiential Avoidance: Understanding How Heightened Therapist FOI Relate to a Weaker Working Alliance

One theory that helps us to understand therapist FOI and its relationship to the alliance is experiential avoidance, the behavior of avoiding negative feelings as they arise in the moment. Experiential avoidance has most recently been popularized by Steven Hayes through the rise of CBT inspired acceptance and commitment therapy (ACT) (Hayes et. al, 1996). However, it has deep roots in psychoanalysis, where we might think of experiential avoidance in terms of defense mechanisms, unconscious mental processes used to avoid anxiety or conflict (Freud, 1936). It can also be understood as conceptually related to gestalt theory, which emphasizes the need to be open to the entirety of an experience (Wertheimer & Riezler, 1944). Finally, one might frame these same ideas in terms of existential and humanistic psychologies where psychopathology is related to the avoidance of intense and unavoidable life realities, such as death and freedom (Yalom & Lieberman, 1991). Throughout these different theories, there is a common thread, which is that when individuals become overwhelmed by their own feelings, they seek to avoid them, which in turn leads to detrimental outcomes and/or symptoms (Hayes et. al, 1996).

In the case of therapist FOI, we can wonder if these negative and uncomfortable feelings arise in a session in response to heightened patient affect which perhaps the therapist experiences as evidence of their failure to care for and help the patient. Perhaps in response to these feelings, therapists trying to *avoid* feeling their own FOI, employ techniques such as reassurance, interpretation and criticism of the patient, all in the service of quieting their own sense of helplessness. In other words, we might hypothesize it is not just the *patient's* negative affect that the therapist is avoiding, but also, importantly the *therapist's own* negative affect as related to FOI (Rousmaniere, 2016). To animate this further: the patient's negative emotions seem to say to the therapist, "You are not helping me!" and the urge to reassure the patient and/or interpret the patient's distress are ways of shutting down precisely the feelings brought on by this message. Interpretation has been found to have both positive (Levy, Hilsenroth & Owen, 2015) and negative (Piper et. al, 1991) relationships with the working alliance, while supportive techniques like reassurance have been found to be effective in short term therapy (Hellerstein et. al, 1998). What I am proposing is that techniques, such as interpretation and reassurance, which could be useful in the right moment, appear to move the patient away from the emotions they are feeling in the observed sessions. By moving the patients away from their emotions, therapists *might* convey to the patients that these emotions are intolerable for the therapist, potentially leading to a breakdown in the alliance. While based on the literature referenced above, this inference is a speculative one and merits further experimental examination.

In the two clinical moments below, taken from sessions in which FOI increased dramatically and the working alliance decreased, we can see this process illustrated

vividly. While I will briefly suggest possible alternative responses that the following two therapists could have taken, I will explore more deeply what alternative responses can look like in moments when patients express negative emotions in the next section on mirroring and reformulation.

Clinical moment 1, the exhausted student:

Becca[3] showed up exhausted to her 7th session with her therapist Clara. An 18-year-old college student, Becca had stayed up late the previous night studying. She had initially presented to the clinic with depressive symptoms, including low self-esteem, sleep difficulties, and a sense of hopelessness. During the first few weeks of treatment, she came down with a virus and ended up dehydrated and briefly hospitalized. The session presented below is her first one after recovering and returning to therapy. In this segment, her therapist appears to be emotionally activated by Becca's negativity and self-criticism.

Becca: Since I got home from the hospital, it's been a lot of rest.

Clara: You got some TLC.

Becca: Yeah, it's really nice. It's good for me.

Clara: And you slept?

Becca: I slept a lot. I didn't get as much homework done as I should have. So I'm already-

Clara interrupts.

Clara: It's like your body was saying "no mas!"

Becca nods.

[3] All identifying information has been altered to maintain patient confidentiality.

Becca: Yeah. Literally. So then I came back yesterday to school and went to the library until 4am last night and it just feels like this whole week of rest has been shattered by the homework I had to do. Feels like I kind of want to step back. But it's okay. I'll take a nap after this.

Clara: Okay. Yeah, yeah.

There is a pause and Becca sighs.

Clara: I'm feeling these very strong maternal feelings towards you. I want to say things like (using a deeper voice and playfully shaking her fists), "4 o'clock in the morning! That's so unhealthy!"

Becca begins to giggle.

Becca: I know, I know.

Clara laughs.

Becca: I haven't told my mom.

Clara: You're obviously reacting to feeling a lot of pressure at school.

Becca: Yeah, yeah.

Clara: Were you visiting social media when you were home –

Becca interrupts.

Becca: Not really, no. It was a chance to get away from that. I didn't feel as isolated as I thought I would, usually I have some FOMO (fear of missing out), like my friends texted me about a party but I was like "I'm home I told you," but whatever and I was like, "have fun"

Both laugh.

Becca: I'm gonna watch my Netflix and be with my cat. So it wasn't as bad as I thought it could be.

Clara: It could be that you were already feeling so shitty that you didn't even care. Was that it?

Becca laughs.

Becca: No, no.

Clara: Or it could be that something shifted and it didn't feel as important to be comparing yourself or being on social media.

Becca: Yeah.

Clara: I raise it in part because you brought it up last time and we put a pin in it but you have to tell me whether that is something that is still front of mind for you.

Becca: Hm. Not right now, not really. Right now it's just school and stress.

Clara: I'm thinking back to our earlier conversation and how there are real anxieties in your life, you know? Like stuff that really is anxiety provoking and missing a week of school and feeling really sick and having work pile up, that's really anxiety provoking, that's the real thing. Yeah.

Becca: Yeah. I'm not sure why, but I convinced myself that I had done enough work and I was struck in class by how lost I was. So that was stressful for me so now I have to decide whether should read some of the things that I didn't get to read last week or catch up on the sleep I missed last night.

Clara: What were you working on until 4 in the morning?

Becca: There were reading responses and I had to respond to two of three but I the one that I didn't respond to ended up being super important, so I felt bad, now I am going to get a bad grade on my reading response because I clearly showed that I didn't do all the readings.

Becca groans and smiles.

Becca: It's fine.

Clara: You did what you were supposed to do. You did two.

In this section, Becca displays self-criticism and potentially self-destructive behavior. While she surely has good intentions, namely to soothe her patient, Clara's responses appear to direct Becca away from a difficult affective state. Three therapist responses stand out.

First, Clara appears to be subtly critical of Becca's behavior to steer her in the "healthy" direction. In the guise of playfulness, Clara takes on the role of a critical

mother, raising her voice and expressing a desire to scold her patient for staying up too late. The patient responds by saying that she had not told her mother yet, presumably because her mother would have reacted negatively, much like her therapist. Becca seems to be focused on her exhaustion, but her therapist is focused on - and seemingly frazzled by – the patient's "unhealthy" behavior. In another subtly critical moment, Clara asks whether Becca was "visiting social media" when she was home recovering. Becca interrupts her to say she was not. Clara defends bringing up the subject in the first place ("I raise it in part because you brought it up last time … but you have to tell me whether … that is still front of mind."). In both these examples, Clara seems to subtly criticize Becca's behavior in a seeming effort to help Becca be more "healthy," but the apparent effect is that Becca responds defensively. Alternatively, Clara could have focused on the feelings of exhaustion – what is it like to be awake at 4AM? How does the exhaustion feel in her body? These types of responses will be more fully explored in the following section on mirroring and reformulation.

Clara also appears to move Becca away from self-critical feelings by trying to reassure her. When Becca claims that she feels "bad" and implies a sense of guilt for not having fully completed a homework assignment, Clara tells her that "you did what you were supposed to do," instead of potentially exploring the "bad" feeling. In a similar moment, Clara interrupts her patient when the patient begins to criticize herself for her productivity, again with an attempt at playfulness, claiming that the patient's body had told her "no mas!" Clara seems to be telling Becca that it's not her fault that she did not finish her work because her body was so exhausted and could not do it, an attempt to

reassure and comfort her. Becca responds by saying “yeah,” but she does not stay with the self-critical feelings, continuing instead with details of a story about her week.

Finally, Clara avoids Becca’s feelings by posing close-ended questions that seek to direct Becca’s response, precluding the possibility of emotional exploration. For example, when Becca says that she did not miss spending time with her friends, Clara says, “It could be that you were already feeling so shitty that you didn’t even care. Was that it?” Becca responds, “no, no” which leaves Clara feeling deflated and Becca misunderstood. This happens again moments later when Clara responds, “Or it could be that something shifted and it didn’t feel as important to be comparing yourself or being on social media.” Becca gives a half-hearted “yeah” but does not expand and returns to her story. In short, while there are attempts to name Becca’s emotional state, in each of these moments the therapist struggles to stay in the present and with the patients emotional experience.

It should be noted that none of these comments by Clara are bad or wrong, nevertheless they do appear to limit the potential connection between the patient and the patient’s feelings as well as between the patient and her therapist. This lack of connection is expressed not only in Becca’s consistently negative affect throughout the session but also in the diminished patient-reported alliance rating and increased therapist FOI. While we are unable to determine the direct relationship between this moment and the patient’s overall valuation of the working alliance in this session, it is notable that the patient’s assessment of the working alliance in this session was low and the therapist levels of FOI were high.

Clinical moment 2, the lonely mother:

Julie, a musician in her 50s, sought therapy for an overwhelming sadness and hopelessness that had arisen with coinciding events: her young adult son had moved to another country to live with his father two years earlier and she had been unable to find a steady job in the United States. She and her therapist Dan spent the first several sessions talking about her history of sadness, including a suicide attempt in her 20s and a verbally and emotionally abusive marriage that ended in divorce a few years earlier. In session 9 (of 20), Julie had just returned from visiting her mother who was suffering from dementia. In this segment, Dan appears to respond to the intensity of Julie's sadness and despair which begins when she describes dreams about her distant son.

> Dan: There's also the dreams about your son and I was going to say, I have certainly been thinking about how powerfully *sad* it is to be so far from him.

There is a long pause as Julie begins to cry but holds back tears.

> Julie: I had *no* idea. I mean, *no* idea how profound this would be. I mean I knew when I said, "you can go" and feeling like and knowing that I wanted him to stay but I'm going to be magnanimous and this is what he wants and what he needs. So I let my son go and I just had no idea-

Julie pauses to wipe away tears.

> Julie: No idea how hard and painful it would be. I mean we let our children go.
>
> Dan: Mhm.
>
> Julie: They grow up! I left home at 17 so given that that was my trajectory in life and so I told myself, okay, my son is 17 and he will go off and never really imagined that, I mean I kept saying I'm prepared for this, I'm prepared for this, but *not this soon*. I don't know what it would be like if I had gotten to spend more time with him but-
>
> Dan: One thing we didn't really speak about last time when we talked about your son. There's clearly the sense of loss explicitly related to your situation – you're here, he's there. But it seems like there might also be a healthy, if painful developmental separation happening or in the midst of happening in terms of-

Julie: he is more independent.

Dan: Right.

Julie: Yeah.

Dan: And I wonder if that's part of the mix as well. Not to minimize the pain of the situation happening right now but I'm thinking about how your role has changed towards him and that simultaneously your role has changed towards your mother, or it changed kind of a while ago, but every time you visit her, I imagine it's jolting.

Julie: Well there's a lot of crap wrapped up with her as well and as you say this, I'm just making a connection which is that my mother wasn't there. Even if she was physically there, she was emotionally absent, and boy is she *really* absent now. And my big fear is that I'm absent and-

Dan: Are you gonna do the same thing to him that your mom did to you? To put it crudely.

Julie: Well I know that I'm not doing that to him but the emotional reaction is, I am. I'm not there with him when he's going through a really rough time emotionally. And I'm "there" but I'm not physically there as he has had a really tough time these last few days and I feel helpless. So.

Dan: Can you say more about the helpless feeling?

Julie: It's that "I'm so far away, I'm so distant." He's 18 but he still needs moral support. And I can't provide that to him and it's so, so painful.

Dan: Is it possible the physical discomfort you were describing earlier is related to the feelings you're describing now?

Julie: Well I feel this in my heart, it's very heartfelt. And that is more like carpel-tunnel, just because I've been sitting in front of a computer doing this same motion over and over again.

At the start of this moment Dan invites Julie to talk about her sadness and she feels safe enough to do so. However, as the intensity of her emotions increase, Dan's responses repeatedly appear to lead the two of them away from that intensity.

First, Dan tries to reassure Julie but, much like Clara in the previous clinical anecdote, only ends up moving her away from the emotion while not successfully soothing her. When she begins to cry and express deep sadness about her separation with her son, Dan replies, “There’s clearly the sense of loss explicitly related to your situation – you’re here, he’s there. But it seems like there might also be a healthy, if painful, developmental separation happening.” The surface communication is: ‘your sadness is normal and healthy.’ However, in trying to normalize Julie’s feelings, there may be another communication: *because* these feelings are a response to a “healthy” event, Julie can (should?) stop crying and feeling so sad. Indeed, Julie’s response is to interrupt and try to finish the sentence herself, which leads to some crosstalk before Dan offers another statement that takes Julie away from the felt experience of her sadness. Instead, Dan could have approached Julie’s vulnerability more gingerly, reflecting back to her the feelings of regret (“I kept saying I’m prepared for this, but *not this soon*. I don’t know what it would be like if I had gotten to spend more time with him”) and the sense of loss (“No idea how hard and painful it would be. I mean we let our children go.”). This would have required Dan to tolerate Julie’s negativity.

Another way that Dan attempts to help but seems to distance himself and his patient is through interpretations which seek to provide a coherent explanation to the patient but in delivering them at emotionally intense moments, seem to leave the patient feeling more alone. For example, Dan interrupts a particularly intense emotional comment from Julie and says, “Are you gonna do the same thing to him that your mom did to you? To put it crudely.” He appears to be trying to demonstrate his understanding of Julie’s predicament while also giving her a coherent narrative to explain her behavior

through an interpretation which grounds her behavior in historical relationships and events. The comment both cuts Julie off from her emotional expression while also cutting him and Julie off from each other. She responds quite profoundly, commenting on her son, but also, in a way, commenting on the session:

> Well I know that I'm not doing that to him but the emotional reaction is, I am. I'm not there with him when he's going through a really rough time emotionally. And I'm "there" but I'm not physically there … and I feel helpless.

On the surface, Julie is disagreeing with Dan's interpretation but in a likely unconscious way, she is also communicating what she wants and needs from her therapist – to be physically and authentically present with her emotions. Dan's genetic interpretation was a way for him to avoid doing exactly that.

Finally, Dan uses close-ended questions to assert control over the direction of the session and move away from overwhelming affect. Near the end of the section above, he moves towards the affect, asking "Can you say more about the helpless feeling?" But when Julie begins to get worked up and says, "it's so, so painful," Dan interrupts and asks, "Is it possible the physical discomfort you were describing earlier is related to the feelings you're describing now?" While Dan may be making an accurate observation, the comment moves Dan and Julie away from the content of Julie's helplessness, and in turn forces Julie away from the open ended and unpredictable feeling and toward a yes or no answer. This puts the interaction on his terms instead of hers. It is no wonder, then, that the alliance as reported by Julie at the end of the session suffers, while Dan ends up feeling much like his patient and her son – helpless.

As illustrated in these two clinical moments, the therapists appeared to struggle to tolerate the patient's emotions. Additionally, the data documents a worsening in the

alliance and an increase in the therapists FOI in each of the sessions. While we cannot draw a direct link between the apparent therapist struggles and the quantitative data due to the nature of this study, it is worthwhile to wonder about the connection between experiential avoidance and process variables like alliance, outcome and FOI in future experimental studies.

Mirroring: Understanding How Diminished Feelings of Incompetence Relate to Effective Alliance Building:

Mirroring is a useful theoretical foundation for understanding what is effective in sessions in which there is a corresponding increase in working alliance strength and decrease in therapist FOI. Theories on mirroring are the basis for techniques, used across modalities, in which the therapist reflects the patient's thoughts and feelings either through paraphrasing or in some cases gently reflecting the emotions, themselves (Antaki, 2008; Ferrara, 1994). The following section will discuss two examples from sessions in which it was recorded in the quantitative data that patient reported alliance improved and therapist FOI decreased. Notably, in these examples, the therapists utilized mirroring and reformulation to different degrees, which may have contributed to the ability/willingness of the patient and therapist to stay present and connected with the thoughts and feelings raised by the patient.

The concepts of mirroring and reformulating have deep and solid roots in psychological research and theory. [4] Early parent-child interactions in which the parent

[4] There is extensive literature related to the concept and use of mirroring in both human development and psychotherapy but this dissertation is not primarily on mirroring but on therapist feelings of incompetence.

can adequately reflect back to the child their emotions and actions, both through words and movement, give the child the first seeds of their sense of self by indicating to the child that their feelings and behaviors have meaning (Mahler, 1967; Winnicott, 1971; Stern & Sander, 1980). In their bestselling parenting guide, Faber and Mazlish based their philosophy on the concept that children are empowered to cooperate and succeed when their feelings are acknowledged first (Faber & Mazlish, 2012), and randomized control trials offer evidence that this method does indeed improve child mental health and positive behavioral outcomes (Joussemet et al, 2018).

In psychotherapy, mirroring and reformulating techniques been used across different modalities (Knol et. al, 2020). From a humanistic perspective, Carl Rogers pushed therapists to focus on reflective listening, in which the clinician sincerely mirrors the patient's experience through verbal and potentially physical actions (Rogers, 1957). Gendlin and others complicated this technique emphasizing that Rogerian mirroring and reformulation should draw the patient's attention to the parts of their speech and feelings that are more ambiguous in order to clarify them (Gendlin, 1962).

To some readers, the observation that these techniques are useful may seem somewhat obvious. Indeed, mirroring and reformulating are fundamental techniques taught to beginning therapists, if not assumed that they already possess. Ideally, these techniques communicate to the patient that they have been understood without actively trying to shift the emotional tenor of the session. Yet if these techniques are simple to employ, why might therapists struggle to employ them? We can hypothesize that in the

That said, I will attempt to refer to the works that have most influenced my thinking and understanding of how mirroring can playout usefully in relation to FOI.

absence of specific experience or practice on the part of the therapist, these techniques are easier to employ when the patient's emotions are less intense.

Basketball provides a nice analogy here. Players shoot consistently worse, as expected, with opposing players applying defensive pressure like a hand in their face or bodily proximity causing a rushed shot or poor shot mechanics (Csataljay et al, 2013). Correspondingly, in therapy, a therapist might perform worse at a skill, like mirroring, in the presence of significant psychological defenses from the patient. In other words, when patient affect is elevated, a therapist may feel the urge to rush the patient - and thus themselves – away from the heightened emotional state. They may try to reassure the patient, interrupt them, distract them or steer them towards a certain conclusion – unintentional actions we saw therapists do in the previous part of the qualitative section. As will be discussed in the next section, it is possible that therapist practice or experience with the particular elevated emotion of the patient (anger, for example) could make it easier for the therapist to tolerate the emotion and act to soothe the patient.

In trying to figure out what the therapists were doing during the sessions that saw improvements in WAI and decreases in FOI, therapists appeared to mirror and/or reformulate patient content and affect in high stakes moments. As stated earlier, this study cannot authoritatively conclude that there is a direct link. What follows are two snapshots of such moments in alliance-focused psychotherapy sessions. In the first, a therapist rephrases an anxious patient's concerns into short, economic, statements about their feelings. In the second, the therapist helps a depressed patient to slow down by repeating the patient's feelings back to her and asking open ended questions which help the patient feel understood. In both anecdotes, the therapist stays in the moment of

elevated affect without pushing the patient in any direction. The patients in both scenarios indicate that they feel understood both verbally and in their responses on the WAI at the end of the session which indicated vastly improved alliances.

Clinical moment 3, the anxious scientist:

In their 13th session, Karen, the therapist, and her patient, Diane, discussed Diane's decision to use emergency contraception after a condom breaks during intercourse with her boyfriend. A 25 year old graduate student in science, who sought treatment for general anxiety symptoms, Diane did not want to have a baby, while her boyfriend, also a student, wanted to consider having the child together. In the context of this disagreement, and with pressured speech and hand movements, Diane talked about the dynamics in the relationship.

> Diane: I just think there is this added pressure and there is no time to let things grow and discover and learn and I think that that's why the relationship was so nice before, because we weren't pressuring each other or setting these plans. It was just kind of like week by week and then all of a sudden, another Christmas went by.

At this moment, Karen interjects but speaks slowly and deliberately.

> Karen: So what feels right is to not feel that there is some rule or some pressure that is placed on you, what feels right is to listen to how it feels in the moment right now.

> Diane: Yeah. And on a day-to-day basis, sometimes it's high, sometimes it's low, but the net trend is - if love is the y axis, it's gonna go up, right? Because through the ups and down you still come out together, or maybe you don't and that's what you do to find out.

Again, Karen slows down.

> Karen: Mhm. So you're saying that for you in particular, for your love to grow, you need to feel safe from that pressure and safe to listen to yourself and allow yourself to come up with your own timeline and do things when it feels right.

Here, Diane pauses for the first time in several minutes and sighs. Now her vocal speed slows to match her therapist's.

Diane: Yeah. Yeah. I mean, doesn't that sound pretty, like….sane?

Karen: It does.

Diane: Yeah.

Karen could approach Diane's distress and heightened affect in several ways. She could try to reassure her by telling her not to worry about the relationship or that it is her right to decide what to do with her own body. She could also try to interpret Diane's distress in the context of Diane's childhood experiences, previous relationships, or the loss of a loved one. What she did instead of these options is to reflect and reformulate Diane's words back to Diane. To do this accurately, Karen had to listen very closely and attentively and speak purposefully. Based on her body language and rate of speech, Diane appeared to be soothed by Karen's responses – not because of distraction or reassurance but by feeling understood. She indicates this both by saying, "yeah," but more importantly by her changed affect – she speaks noticeably more slowly and quietly. At the end of this session, Diane's rating of her and Karen's working alliance is higher and Karen rated her FOI lower than after any session thus far in their work together.

Clinical Moment 4: The self-critical actress

Claudette, a musician, sought therapy for help with low self-esteem and symptoms of depression. After missing her originally scheduled 3rd session, Claudette

showed up to the re-scheduled session apologetic, self-critical and very emotionally activated. Her therapist, Linda responded in the transcript below:

Claudette: I'm so sorry about Tuesday, I didn't mean to waste your time.

Linda smiles warmly.

Linda: It's okay. It sounded like it was a busy day.

Claudette: It was so annoying. My agent sent me to an audition with all of these much more attractive women. It was just humiliating. Then they ran behind too. Ugh, it was so horrible and I was so upset and then I missed therapy which I was really looking forward to. And like, I always just have this zoom out thing after bad auditions like what am I doing and why am I doing it…and yech and I feel so gross and embarrassed, and I already know before I go in that I'm not going to be what they want.

Linda: There's so much shame in all those feelings. The gross. The humiliation. The embarrassment.

Claudette: It feels *gross*.

Linda: Can you say more about that grossness?

Claudette: It feels wrong, I just feel like so, I feel like everyone there is like why is this fat girl here? Why did they send her out on this?

Linda: It feels totally hopeless.

Claudette: It feels hopeless. It feels like they are so disrespectful. And I actually feel like I was feeling hopeful, I was like 'I'm going to meet Linda, I'm going to see my friends afterwards, this is such a nice day.'

Linda: So coming to therapy was part of that hope.

Claudette: 100%

Linda: What is it about coming here so far?

Claudette: It's just been really nice to have time to take stock, just to be present with someone and to, I don't know, yeah.

Linda: Taking stock.

Claudette: Yeah. It just feels really soothing, like a gift. Even though it's hard. I'm going to cry again. Sorry.

Tears begin to stream down Claudette's face.

Linda: You feel the need to apologize.

They share a laugh.

Claudette: I know! Ugh. It's so nice to have and it feels so frustrating to – I also just get mad at myself because I feel like it's been a better week and why do I let one small thing get to me and not just spiral?

Linda: That audition really knocked you off that good feeling.

Claudette: Totally. (long pause). Totally.

In the beginning of the session, Linda successfully uses the tidal wave of emotion as an opportunity to come closer together with her patient, as opposed to fleeing the affect for a safer emotional place for herself. Claudette indicates that she feels closer at the end of the session with her words, saying "yeah" and "totally" and describing the therapy as "soothing." The evidence for this closeness is not only the verbal content but also physical - the shared laugh at one of Linda's observations and Claudette's more measured and intentional manner of speech. How does Linda accomplish this? I would suggest that it is her mirroring, reformulating and open-ended questioning. In some cases, she simply repeats the words that Claudette uses, saying, "taking stock," which receives a calm, "yeah" in reply from her patient. In another part, Linda picks up on Claudette's use of the word "gross," and repeats it back to her but with a definite article, "the gross," to which Claudette leans in, emphasizing again, "it *feels gross.*" From this

place of connection, Linda tries to go deeper, asking to hear more about the grossness which allows Claudette to express her sense of hopelessness.

Like in the previous anecdote, Linda has other options in her response. She could have reassured Claudette that she will surely get future roles. She could have analyzed her absence of the previous session. She could have tied Claudette's self-criticism to the way her mother criticized her as a young child. She could have focused very specifically on the content – the nature of the audition, the other women at the audition, Claudette's professional goals. But the content is both important and irrelevant at the same time. Linda is hyper attuned to the content so that she can reflect it back in a way that makes Claudette feel understood and connected. Yet, she does not get hung up on the details of the audition or the scheduling, instead focusing her replies on the emotional content. When she asks questions, they are open ended which allows for the possibility of more openness and vulnerability from her patient, even in the face of great affect from Claudette. It seems that Claudette feels connected and understood, reflected in her improved alliance rating at the end of the session. Similarly, Linda seems to feel more competent as a therapist, reflected in her decreased FOI score.

Limitations

The way this study has approached FOI and its relationship to the alliance and outcome has a few limitations.

First, this study did not consider the specific pathology of the patient participants, which may contribute to the FOI experienced by therapists. One study found a correlation between the inadequacy factor that this study used to measure FOI and

‘cluster B’ personality disorders (Betan, et al 2005). This is not to say that therapist FOI could simply be explained by the presence or lack of patients with cluster B personality disorders, but instead that patient pathology can add to the complexity of determining the source of a therapist’s FOI. Furthermore, there were no patients diagnosed with cluster B personality disorders among these participants.

Another limitation for the study is the size of the therapist and patient sample. Five therapists, all Caucasian psychology doctoral students, participated in the study. The patient sample was similarly small, with only 8 patients included, and demographically only slightly more diverse than the therapists (see Tables 4 and 5). Research has found mixed results when it comes to an association between race and class on self-confidence with some studies finding a significant association (Twenge & Crocker, 2002), while others finding a relationship only insofar as race interacts with age (Shaw, Liang, & Krause, 2010). These findings raise questions about the extent to which race, class, age and other identity markers might interact with feeling of incompetence. The inclusion of more therapists and patients with greater demographic diversity would increase the generalizability of these findings.

Worth noting as well is that the author was a therapist-participant in two of the eight cases examined here. How this overlap plays out in terms of analysis is impossible to fully parse; it is possible that it informed the interpretation of the qualitative data.

Future Directions

Despite these limitations, this study contributed to our understanding of feelings of incompetence and their impact on the therapeutic process in meaningful ways. The study identified three trends:

First, the study found that for an individual session, there is an inverse association between FOI and working alliance strength, an inverse association between FOI and outcome and a positive association between working alliance and outcome.

Second, the study found that FOI's impact on outcome is almost entirely mediated by the strength of the working alliance, while the working alliance's impact on outcome is not significantly mediated by FOI. In other words, the study found that for a given session, a therapist's feelings of incompetence are important for insofar as those feelings impact the working alliance. This means that heightened therapist FOI should prompt curiosity about the state of the working alliance with the patient, not a conclusion by the therapist that they are, indeed, incompetent.

Third, in exploring these sessions qualitatively, I observed that in these "negative" sessions therapist appear to be more active in moments of intense patient emotions. In addition, when the therapists can calmly attend to these intense moments, using basic techniques like mirroring, reformulating and open-ended questions, the working alliance for that session as reported by the patient is stronger. If therapists are overwhelmed by their feelings, they appear to rely on techniques that steer the dyad away from emotional intensity to a topic or emotional frequency where the therapist can feel more competent and effective, with the sadly paradoxical result being a weakened alliance and worse outcome. While this observational method limits our certainty in making the claims above, the observations are still worth further exploration.

There are several clinical implications of these trends (discussed below), of which additional systematic examination of these trends is warranted.

FOI as an Alliance Alert

From these findings, therapists might learn to see an increased FOI as an alert, not only about their countertransference, but also about the state of the working alliance and the potential need for intervention. Rather than take an increase FOI as reflecting patient functioning and/or trajectory of change in treatment, FOI can provide insight into two other processes. First, therapist FOI may be an alert to a potential rupture in the alliance. Research has found that treatments by psychotherapists who receive *formal* feedback about their patient's symptom change during the treatment are associated with more patient symptom change than treatments where psychotherapists do not receive feedback (Lambert et. al, 2001). This dissertation suggests that clinicians might have an *informal* feedback mechanism for working alliance strength or deterioration.

Second, the presence of FOI can be an opportunity to refocus the therapist away from the need to remove patient suffering, which is often the first impulse, and towards alliance repair. Therapist attention and intervention can be focused on the fundamentals of the alliance: more fully connecting with the patient on an emotional level, understanding the patient's therapeutic goals and ensuring that there is a joint understanding and agreement of how to achieve those goals. The qualitative section of this study suggests that one way to accomplish this is through the simple, yet difficult, work of mirroring, reformulating, and acting from a place of openness and curiosity.

Train Therapists in Simple Skills

The findings in the qualitative section of this study suggest that much benefit could come from teaching therapists the basic listening skills that can help therapist and patient reconnect when there is patient dysregulation, potentially leading to ruptures, in sessions. Therapist training at the doctoral level often assumes that incoming trainees are well versed in basic listening, mirroring, and reformulating skills. There is no APA required course for these skills. Instead, much training for therapists seems to take for granted these skills and "skip ahead" to learning whole modalities with multi-step phases as well as conceptualization models that inform how we understand and diagnose our patients (Elkins, 2009). There's nothing wrong with that learning, but the qualitative section of this study suggests we may be skipping an important more fundamental education. One model– reflective listening – offers a path forward (or backwards in this case) in terms of therapist training.

Reflective listening is a therapeutic practice, pioneered by Carl Rogers, in which the therapist demonstrates empathy through attempting to achieve moments of "congruence" with the patient so that the patient feels understood and accepted (Rogers, 1957).[5] While there is healthy debate within the humanistic field, there seems to be broad agreement that reflective listening can look like an exact parroting of words or a rephrasing, with the most important part being the patient's emotional state is verbally reflected back to them. Rogerian scholars add that it is vital that the words come from an authentic place, lest the patient feel insincerity and thus feel manipulated

[5] Rogerian theory and techniques are obviously a rich, deep and broad area of study and one that this dissertation will not be able to even partially cover. The point of bringing in his theory and technique is to suggest their utility in rupture-repair processes during alliance focused psychotherapy work.

and that while the technique can appear simple it is, like all relational dynamics, complex in its own way (Arnold, 2014). An example from the qualitative section above is in the 4th case:

> Claudette: It was so annoying. The agency sent me to an audition with all of these much younger, much taller models and I am five feet tall. It was just humiliating. Then they ran behind too. Ugh, it was so horrible and I was so upset and then I missed therapy which I was really looking forward to. And like, I always just have this zoom out thing after bad auditions like what am I doing and why am I doing it and I had to dance around looking at a phone for the audition and yech and I feel so gross and embarrassed, and I already know before I go in that I'm not going to be what they want.
>
> Linda: There's so much shame in all those feelings. The gross. The humiliation. The embarrassment.
>
> Claudette: It feels *gross*.
>
> Linda: Can you say more about that grossness?

Here, the therapist manages to help the client feel understood by both repeating parts of the exact words (humiliating, gross, embarrassed), adding a summarizing word of her own (shame) and conveying in her own affect that she understands the pain. The evidence of the patient's increased emotional regulation and connection with the therapist are impossible to fully convey without watching the video, but one can see in the patient's repetition of the therapist an example of the "congruence" that Rogers talks about. This connection allows the therapist to follow up with an exploratory question, also part of reflective listening, which the patient can use a springboard for more emotional expression (Rogers, 1957).

While Rogers might argue that reflective listening interventions alone can be the basis for patient outcome improvement, this study does not attempt to make a claim in

on that issue in any direction. In other words, this study is agnostic on the import of interpretations in psychotherapy overall but does observe that they can appear to serve as a form of affective avoidance. Instead, this study argues that, at the very least, reflective listening skills are a meaningful part of a therapist's toolkit and, specifically, that they are especially useful in responding to moments of patient affect or rupture in the therapeutic process. They could be more explicitly taught to therapists who could practice them in non-session moments – like a role-play with other trainees – to build a type of muscle-memory such that reflective listening can be deployed more readily in difficult session moments.

The Promise of Deliberate Practice

In addition to a lack of training or practice, the other impediment to therapist's implementing reflective listening skills is a therapist's FOI. At the risk of being repetitive, this study observed that when patients express distress in sessions, therapists can appear to respond more actively, coinciding with their own reports of increased FOI (on the CTQ). In other words, even a therapist well-trained in reflective listening might be unable to draw upon useful skills if they are overwhelmed by their feelings. Fortunately, there are promising new initiatives for managing with these feelings through the deliberate practice model established by Dr. Tony Rousmaniere and his colleagues. His model is based on the idea that the empathic expression in therapy requires therapists to develop their capacity to withstand the psychological distress caused by working with distressed patients (Rousmaniere, 2016; Elliott, et al., 2011).

Deliberate practice in therapy is inspired by a larger popular and academic interest in deliberate practice that sees high-level skills in all fields, from sports performance to medical procedures, as tied more to intentional learning and repetition than talent (Ericsson, 2004). While initially this idea was very trendy and popularized in pop psychology books by Malcolm Gladwell and Angela Duckworth, more recent research has questioned whether talent and financial resources, among other factors, play a bigger role than Ericsson initially suggested (Abu-Odeh et. al, 2009; Campitelli & Gobet, 2011).

In terms of its application to psychotherapy, Rousmaniere has developed a series of exercises to help trainees practice staying emotionally present during psychotherapy sessions instead of using avoidance and defense mechanisms to steer away from distressing patient affect. In one that would be especially helpful for learning to manage FOI, trainees repeatedly watch videos of their sessions with patients and track the avoidant feelings that come up for them (Rousmaniere, 2016). He compares the shame and self-doubt that arise in these practice sessions to athletes sweating or lifting heavy weights, in that these experiences are somewhat painful but are part of building new skills or muscles (Rousmaniere, 2016). A 2016 study found that in a Canadian clinic, therapists using deliberate practice along with feedback from patients had better patient outcomes than a control group that used neither feedback nor deliberate practice (Goldberg et. al, 2016). Incorporating these exercises alongside training and practice in reflective listening could help trainees as well as more experienced therapists to recognize and manage FOI so that they can better connect with patients in emotionally stressful session moments.

Treatment-Length Study

Largely because of the amount of data available at the time of conducting this study, the focus of this dissertation was on individual session data as opposed to full treatment data. That is to say, the conclusions drawn are based on what happens in a single session, devoid of overall treatment context – a glimpse at a battle instead of an analysis of the whole war. While this approach is very rich and provides important insights into how any single session unfolds, it does not fully consider the context of a session in the larger treatment. For example, a session in which there is an alliance rupture may appear to be a disaster for the treatment, but if the dyad can repair the rupture, perhaps in the next session, the alliance may bounce back to a stronger place than before. Indeed, when one zooms out from the single session vantage point to a whole treatment view, it is possible to completely flip the narrative about the treatment. In this narrative, alliance repairs are not meaningless victories but instead promote better treatment outcomes such that a meta-analysis found that rupture-repair resolution was moderately but significantly associated with better outcomes (Eubanks, Muran and Safran, 2018). While there are important analyses to glean from the individual session focused approach, a single bad session does not necessarily destroy a treatment and may, in fact, be a vital component of overall treatment success.

Conclusion

This study set out to explore therapist feelings of incompetence in the therapeutic process from both a quantitative and qualitative perspective. While previous studies

have explored therapist descriptions of such feelings, as well as the impact of negative countertransference feelings and their relationship to therapeutic process constructs like the working alliance and outcome, this is among the first attempts to look at the role of these specific feelings in an individual therapy session using therapist and patient data. The results revealed that therapist feelings of incompetence impact the working alliance directly and outcome change indirectly, through the working alliance. Furthermore, qualitative analysis suggested that therapist feelings of incompetence might be associated with specific avoidant behaviors which may negatively impact the working alliance. Next, this study proposed possible remedies for these avoidant behaviors, from training in reflective listening to deliberate practice focused on tolerating unpleasant emotions. Future directions for research might focus on looking at FOI across whole treatments and the role of these feelings in alliance rupture and repair.

Tables, Figures and Graphs

Table 1: *Descriptive Statistics and Correlations for Study Variables* [c]

Variable	*n*	*M*	*SD*	1	2	3
1. Feelings of incompetence [a]	131	17	5.15	—		
2. Working alliance [b]	131	69	10.5	−.32**	—	
3. Outcome change	123	-.29	11.5	.37**	−.26**	—

[a] Based on “inadequacy” factor in Countertransference Scale

[b] From the Working Alliance Inventory

[c] Values standardized so that they all have mean 0 and std 1

** $p < .01$.

Table 2: *Regression Analysis*

Effect	Estimate	*SE*	95% CI		*p*	R^2
			LL	*UL*		
OQ change on FOI and WAI						.306
Feelings of Incompetence	.224	.078	.069	.377	.005	
Working Alliance	−.439	.078	−.593	−.285	<.001	
OQ change						
Feelings of Incompetence	.365	.082	.203	.527	<.001	
Working Alliance	−.511	.076	.012	.023	<.001	
FOI on WAI	−.32	.083	-.485	-.155	<.001	

Table 3: *Stratified Regression Analysis*

Effect	No. of Coefficients	Mean of the Coefficients	Coefficients SD	*p*
OQ change on WAI stratified by FOI (model 1)	7	-0.41	0.25	.05
OQ change on FOI stratified by WAI (model 2)	7	0.31	0.32	.16

Table 4: *Therapist Demographics*

Category	**Total Sample**	**Mean**	**SD**
Gender			
Male	1		
Female	4		
Race	4		
White	4		
Other	1		
Age		39.2	10.54

Table 5: *Patient Demographics*

Category	**Total Sample**	**Percentage**	**Mean**	**SD**
Gender	8			
Male	1	12.5		
Female	7	87.5		
Race	8			
White	5	62.5		
Latino/Hispanic	2	25		
Other	1	12.5		
Age			31.71	12.57

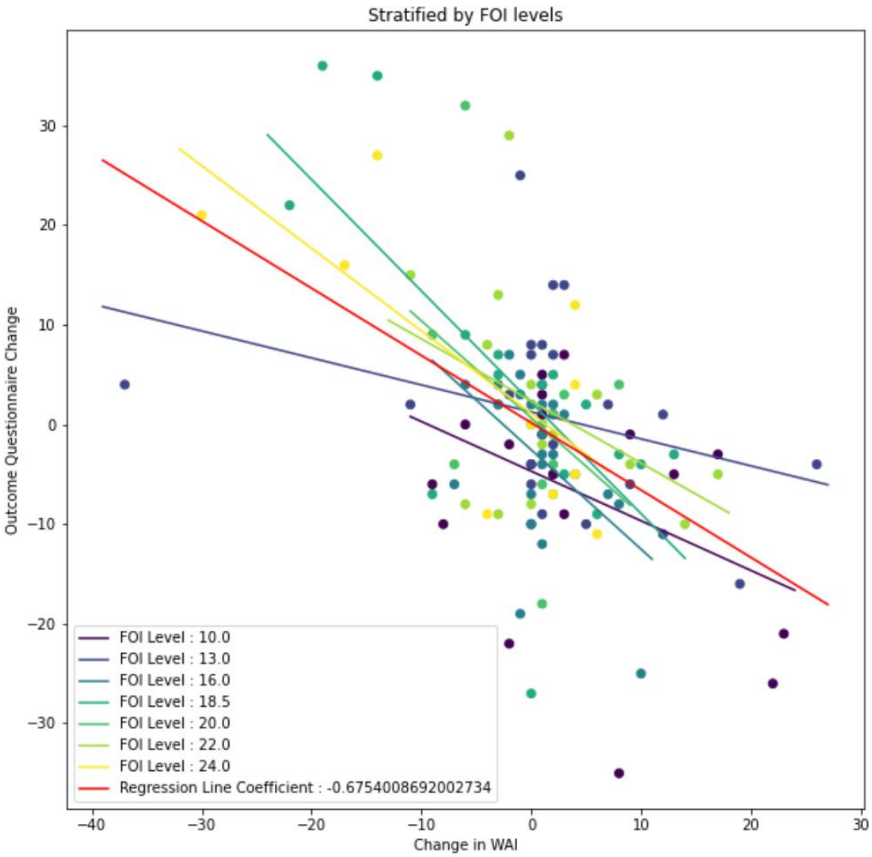


Figure 1. Regression of Change in OQ on Change in WAI for fixed levels of therapist FOI

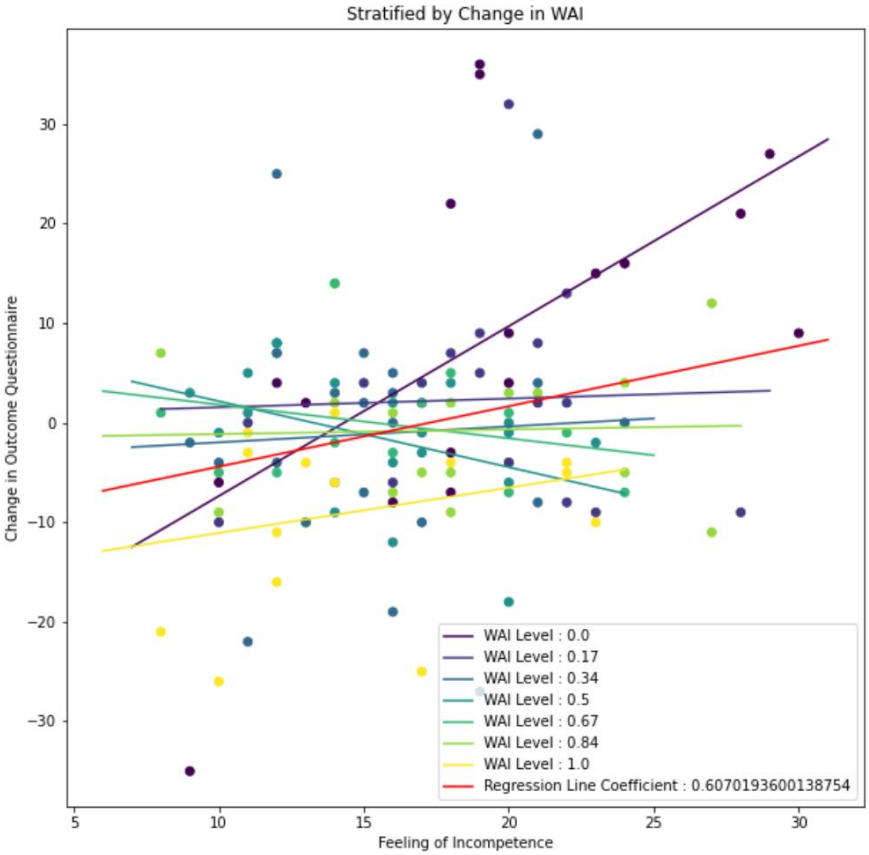


Figure 2. Regression of Change in OQ on therapist FOI for fixed levels of change in WAI

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Appendix

CTQ Items Measuring Helpless/Inadequate feelings (coefficient alpha = .88):

I feel I am failing to help him/her or I worry that I won't be able to help him/her.84

I feel incompetent or inadequate working with him/her.80

I feel hopeless working with him/her.78

I think s/he might do better with another therapist or in a different kind of therapy.67

I feel overwhelmed by his/her needs.62

I feel less successful helping him/her than other patients.62

I feel anxious working with him/her.61

I feel confused in sessions with him/her.52